in these pages. That is one of the purposes of a medical journal.

The article and subsequent debate has provided the opportunity for family physicians to be much more aware of the discomforts, insecurities, and needs of our trainees as we strive to teach them to be sensitive, patient-centred practitioners.

—Nicholas Pimlott MD CCFP
Scientific Editor
—Roger Ladouceur MD MSc FCMF
Associate Scientific Editor

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Positive reinforcement

I spent this morning reviewing the titles of all contributions to this year's issues of *Canadian Family Physician* and "This business of caring" caught my eye.[1] I wondered, Do I respond or not? As a social worker and teacher of behavioural sciences in the Department of Family Medicine at the University of Saskatchewan in Saskatoon I am compelled to do so. Why? Because teaching communication skills involves noting a learner's strengths and reinforcing them through the use of direct and indirect compliments.

Using solution-focused therapy techniques to guide my feedback, I applaud you, Dr Bielawska, for taking the time to put to paper your observations on the struggle inherent in being both a clinician and a healer. What made you do so, and what did you learn from the process? How will you build on your reservoir of empathy and ensure it continues to play a role in patient care? On a scale of 1 to 10, with 10 being the strongest and 1 being the weakest, rate your commitment to attending to the human side of patient care. Now that you have selected a number, scale your confidence in your abilities and skills to do so. What do you need to do to move that number up a notch?

Although you mentioned that "this challenge [is] not taught in any textbook or classroom" you are clearly a young woman who learns via a variety of experiences. Perhaps the world is your textbook? Whatever you are doing you are definitely on the right track. Thank you for taking the time and energy to share your perspective; in doing so, you normalize for your colleagues the inherent struggle of a patient-centred family physician to do right by patients without sacrificing enthusiasm for the science of medicine.

—Gail Greenberg MSW
Regina, Sask

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Focused practice: broadening the scope of family medicine

There are clearly reservations about focused practice.[1] The concern seems to be a perceived threat to comprehensive family medicine. Yet, far from being a threat, focused practices offer a vital dimension by backfilling areas of medical practice that have manpower shortages (eg, FPs that handle dialysis, oncology, and palliative care) and areas in which medical education has been deficient (eg, structural assessment within orthopedics, environmental medicine, and—that great black hole of medical training—nutrition). In addition, there are areas of emerging knowledge dealing with disease entities traditionally not thought to be valid but that are proving to be very real over time (chronic fatigue syndrome, chronic Lyme disease, etc). I can think of several GPs and FPs who have been swimming for years against the current of mainstream medical opinion to work with these often very unfortunate and sick people. The extraordinary patient loyalty they often engender is something we should all note.

We should also take into account the array of complementary approaches, which have been of benefit to a substantial number of people. Some of these modalities have bodies of evidence that might surprise many doctors (eg, acupuncture, homeopathy), while others are more esoteric and remain unfamiliar to most practitioners (eg, traditional Chinese medicine, Ayurveda, anthroposophic medicine) yet have subgroups of patients who benefit from their practices.

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Think of focused practices as broadening the scope of family medicine rather than as a threat. We are all FPs or GPs and many of us have Certification from the College of Family Physicians of Canada. We think like family doctors—indeed, many of us have had long careers in family medicine—and working with family doctors is second nature, notwithstanding the divisiveness of the changes within primary care.

—Craig Appleyard MD CCFP FCFP
Renfrew, Ont

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Focused practices, special interests

I'm not a magician, I'm just an old country doctor.

Dr Leonard H. McCoy,
Star Trek (1967)

When I gave up practising anesthesia after 10 years, I did not think I was a real doctor. When I gave up practising obstetrics after 18 years, I did not think I was a real doctor. When I gave up practising emergency medicine after 28 years, I did not think I was a real doctor.

I have argued for comprehensive, general family medicine, but I see that we are now a specialty. Dr Sandy Buchman, when he was president of the Ontario College of Family Physicians, asked about focused practices, subspecialties, and General Practitioners with Special Interests and got an overwhelming response from colleagues who felt marginalized in family medicine. Now we have a great number of subspecialities, as Dr Gutkin described in his December 2009 article.[1] Dr Gutkin is old enough to remember the hyphenated Canadian, eg, Italian-Canadian, Irish-Canadian, or Ukrainian-Canadian. Maybe now is the time for the hyphenated family physician, eg, sports medicine–FP, geriatric-FP, anesthetist-FP. The Ontario Medical Association Section of General Practice has resisted this